

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0034157</u></p> <p>Facility Name: <u>WOODBIDGE NURSING PAVILION</u></p> <p>Address: <u>2242 N. KEDZIE AVE.</u> <u>CHICAGO</u> <u>60647</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 486-7700</u> Fax # <u>(773) 486-7937</u></p> <p>IDPA ID Number: <u>363585796001</u></p> <p>Date of Initial License for Current Owners: <u>08/01/88</u></p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other _____</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other _____			<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>See Accountants' Compilation Report Attached</u></td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>RICHARD S. SGARLATA, C.P.A.</u></td></tr><tr><td rowspan="3">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001</td><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax# <u>(847) 236-1155</u></td></tr><tr><td>Phone # (217) 782-1630</td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>See Accountants' Compilation Report Attached</u>	(Date) _____	(Print Name and Title) <u>RICHARD S. SGARLATA, C.P.A.</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax# <u>(847) 236-1155</u>	Phone # (217) 782-1630
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Facility Name & ID Number WOODBIDGE NURSING PAVILION

0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>222</u>	Skilled (SNF)	<u>222</u>	<u>81,030</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>222</u>	TOTALS	<u>222</u>	<u>81,030</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,431</u>	<u>539</u>	<u>2,366</u>	<u>13,336</u>	8
9	SNF/PED					9
10	ICF	<u>56,101</u>	<u>3,236</u>	<u>214</u>	<u>59,551</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,532</u>	<u>3,775</u>	<u>2,580</u>	<u>72,887</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.95%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/1/1988

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 8/1/1988 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 33 and days of care provided 2071

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **WOODBIDGE NURSING PAVILION** # **0034157** Report Period Beginning: **01/01/01** Ending: **12/31/01**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	230,777	28,355	7,200	266,332		266,332		266,332			1
2	Food Purchase		270,727		270,727	(26,335)	244,392	(514)	243,879			2
3	Housekeeping	94,330	31,875	154,422	280,627		280,627		280,627			3
4	Laundry	21,009	29,932	77,895	128,836		128,836	(1,648)	127,188			4
5	Heat and Other Utilities			155,499	155,499		155,499	605	156,104			5
6	Maintenance	57,038	39,040	47,286	143,364		143,364	13,334	156,698			6
7	Other (specify):*							2,035	2,035			7
8	TOTAL General Services	403,154	399,929	442,302	1,245,385	(26,335)	1,219,050	13,812	1,232,863			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,160,249	92,853	75,967	2,329,069		2,329,069	(4,623)	2,324,446			10
10a	Therapy			7,650	7,650		7,650		7,650			10a
11	Activities	122,018	5,555	4,400	131,973		131,973		131,973			11
12	Social Services	25,138		4,198	29,336		29,336		29,336			12
13	Nurse Aide Training							208	208			13
14	Program Transportation			3,680	3,680		3,680		3,680			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,307,405	98,408	99,495	2,505,308		2,505,308	(4,415)	2,500,893			16
	C. General Administration											
17	Administrative	107,541		180,565	288,106		288,106	66,243	354,349			17
18	Directors Fees											18
19	Professional Services			354,468	354,468	(233)	354,235	(307,992)	46,243			19
20	Dues, Fees, Subscriptions & Promotions			59,910	59,910		59,910	(45,333)	14,577			20
21	Clerical & General Office Expenses	99,560	3,455	61,293	164,308		164,308	63,765	228,073			21
22	Employee Benefits & Payroll Taxes			525,964	525,964	26,335	552,299	(12,039)	540,260			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,114	1,114		1,114	1,490	2,604			24
25	Other Admin. Staff Transportation			683	683		683	190	873			25
26	Insurance-Prop.Liab.Malpractice			179,239	179,239		179,239	6,020	185,259			26
27	Other (specify):*							38,993	38,993			27
28	TOTAL General Administration	207,101	3,455	1,363,236	1,573,792	26,102	1,599,894	(188,663)	1,411,231			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,917,660	501,792	1,905,033	5,324,485	(233)	5,324,252	(179,266)	5,144,986			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			45,258	45,258		45,258	11,005	56,263			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,689	68,689		68,689	(50,983)	17,706			32
33	Real Estate Taxes			221,160	221,160	233	221,393	3,148	224,541			33
34	Rent-Facility & Grounds			1,091,370	1,091,370		1,091,370	(200)	1,091,170			34
35	Rent-Equipment & Vehicles			9,513	9,513		9,513	12,884	22,397			35
36	Other (specify):*											36
37	TOTAL Ownership			1,435,990	1,435,990	233	1,436,223	(24,146)	1,412,077			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,115	89,168	167,283		167,283	(2,232)	165,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		78,115	210,713	288,828		288,828	(2,232)	286,596			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,917,660	579,907	3,551,736	7,049,303		7,049,303	(205,644)	6,843,659			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,341	30		9
10	Interest and Other Investment Income	(54,223)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(140)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,050)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(37,628)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,895)	20		28
29	Other-Attach Schedule	(41,740)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (133,335)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(72,309)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (72,309)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (205,644)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Capitalized Repairs & Maintenance	\$ (605)	6 1
2	Nursing PPA	(1,367)	10 2
3	Fees PPA	(184)	20 3
4	Office PPA	(14,530)	21 4
5	Employee Benefits PPA	(12,039)	22 5
6	Laundry PPA	(1,648)	04 6
7	Electric PPA	(71)	05 7
8	Repairs and Maintenance PPA	(1,255)	06 8
9	COPE dues	(4,403)	20 9
10	Franchise Tax	(136)	21 10
11	Penalties	(3,965)	21 11
12	Prior Year Legal Fees	(200)	19 12
13	Discounts Earned	(374)	2 13
14	Franchise Tax - Building Company	(250)	21 14
15	Bank Charges	(45)	21 15
16			16
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number **WOODBIDGE NURSING PAVILION**# **0034157**

Report Period Beginning:

01/01/01

Ending:

12/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(514)											(514)	2
3	Housekeeping													3
4	Laundry	(1,648)											(1,648)	4
5	Heat and Other Utilities	(731)		1,336									605	5
6	Maintenance	(1,860)		6,922	8,272								13,334	6
7	Other (specify):*			1,430		605							2,035	7
8	TOTAL General Services	(4,753)		9,688	8,272	605							13,812	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,367)							(3,256)				(4,623)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training			208									208	13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,367)		208					(3,256)				(4,415)	16
	C. General Administration													
17	Administrative			(180,565)	246,808								66,243	17
18	Directors Fees													18
19	Professional Services	(208)		(307,784)									(307,992)	19
20	Fees, Subscriptions & Promotions	(47,160)		1,827									(45,333)	20
21	Clerical & General Office Expenses	(18,926)	250	74,343	8,098								63,765	21
22	Employee Benefits & Payroll Taxes	(12,039)											(12,039)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,490									1,490	24
25	Other Admin. Staff Transportation			190									190	25
26	Insurance-Prop.Liab.Malpractice			6,020									6,020	26
27	Other (specify):*			11,989		27,004							38,993	27
28	TOTAL General Administration	(78,333)	250	(392,490)	254,906	27,004							(188,663)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,453)	250	(382,594)	263,178	27,609			(3,256)				(179,266)	29

Summary B

Facility Name & ID Number	WOODBIDGE NURSING PAVILION	#	0034157	Report Period Beginning:	01/01/01	Ending:	12/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	5,341		5,664									11,005	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,223)		3,240									(50,983)	32
33	Real Estate Taxes			3,148									3,148	33
34	Rent-Facility & Grounds		(200)										(200)	34
35	Rent-Equipment & Vehicles			12,884									12,884	35
36	Other (specify):*													36
37	TOTAL Ownership	(48,882)	(200)	24,936									(24,146)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						562		(2,794)				(2,232)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						562		(2,794)				(2,232)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(133,335)	50	(357,658)	263,178	27,609	562		(6,050)				(205,644)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Woodbridge Building LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 1,093,130	Woodbrige Building, LLC	100.00%	\$	\$ (1,093,130)	1
2	V	34	Rental Expense		Woodbrige Building, LLC		1,092,930	1,092,930	2
3	V	21	Franchise Tax		Woodbrige Building, LLC		250	250	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,093,130			\$ 1,093,180	\$ * 50	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 1,336	\$ 1,336	15
16	V	6	REPAIRS & MAINT.				6,922	6,922	16
17	V	7	EMP.BEN. - GEN. SERVICES				1,430	1,430	17
18	V	13	NURSES AIDE TRAINING				208	208	18
19	V	19	PROFESSIONAL FEES				3,006	3,006	19
20	V	20	DUES AND SUBSCRIPTIONS				1,827	1,827	20
21	V	21	CLERICAL & GENERAL				74,343	74,343	21
22	V	24	SEMINARS AND TRAVEL				1,490	1,490	22
23	V	25	ADMIN. STAFF TRANS.				190	190	23
24	V	26	INSURANCE				6,020	6,020	24
25	V	27	EMP.BEN. - GEN. ADMIN.				11,989	11,989	25
26	V	30	DEPRECIATION				5,664	5,664	26
27	V	32	INTEREST				3,240	3,240	27
28	V	33	REAL ESTATE TAXES				3,148	3,148	28
29	V	35	EQUIPMENT RENTAL				12,884	12,884	29
30	V								30
31	V	17	MANAGEMENT FEES	180,565				(180,565)	31
32	V	19	BOOKKEEPING	310,790				(310,790)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 491,355			\$ 133,697	\$ * (357,658)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 8,272	\$ 8,272	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				51,248	51,248	17
18	V	17	ADMIN. CMP. - M. AARON				69,322	69,322	18
19	V	17	ADMIN. CMP. - F. AARON						19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN				64,401	64,401	20
21	V	17	ADMIN. CMP. - S. KOPLIN				14,751	14,751	21
22	V	17	ADMIN. CMP. - D. MAGAFAS						22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN						24
25	V	17	ADMIN. CMP. - S. LEVY				17,968	17,968	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				29,118	29,118	27
28	V	21	CLERICAL CMP. - S. AARON				8,098	8,098	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 263,178	\$ * 263,178	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 605	\$ 605	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				3,272	3,272	17
18	V	27	EMP. BEN.- M. AARON				4,779	4,779	18
19	V	27	EMP. BEN.- F. AARON						19
20	V	27	EMP. BEN.- S. GOLDSTEIN				8,077	8,077	20
21	V	27	EMP. BEN.- S. KOPLIN				3,381	3,381	21
22	V	27	EMP. BEN.- D. MAGAFAS						22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN						24
25	V	27	EMP. BEN.- S. LEVY				2,494	2,494	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				3,914	3,914	27
28	V	27	EMP. BEN. - S. AARON				1,087	1,087	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 27,609	\$ * 27,609	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	\$ 7,650	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	\$ 7,650	\$	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	89,166	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	89,728	562	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 96,816			\$ 97,378	\$ * 562	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	\$ 8,584	PHARMCOR, L.L.C.	100.00%	\$ 8,584	\$	15
16	V	19	PROFESSIONAL FEES		PHARMCOR, L.L.C.	100.00%			16
17	V	21	CLERICAL & GENERAL	428	PHARMCOR, L.L.C.	100.00%	428		17
18	V	22	EMPLOYEE BENEFITS		PHARMCOR, L.L.C.	100.00%			18
19	V	39	ANICILLARY EXPENSE	50,802	PHARMCOR, L.L.C.	100.00%	50,802		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 59,814			\$ 59,814	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V	10	MEDICAL SUPPLIES	15,730	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	12,474	(3,256)	16
17	V	39	ANCILLARY EXPENSE	13,494	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	10,700	(2,794)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 29,224			\$ 23,174	\$ * (6,050)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON	OWNER	ADMIN	24.86%	SEE ATTACHED	6	12.0%	Dynamic Sal	\$ 69,322	17-7	1
2	MARSHALL MAUER	OWNER	ADMIN	6.76%	SEE ATTACHED	5.1	10.2%	Dynamic Sal	51,248	17-7	2
3	SHARON AARON	RELATIVE	ADMIN	0.00%	SEE ATTACHED	5.14	12.85%	Dynamic Sal	8,098	21-7	3
4	DENNIS NEHMER	OWNER	ADMIN	0.59%	SEE ATTACHED	5.32	13.3%	Dynamic Sal	8,272	6-7	4
5	SUE KOPLIN	OWNER	ADMIN	0.59%	SEE ATTACHED	9.22	20.48%	Dynamic Sal	14,751	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 151,691		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION# 0034157

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

DYNAMIC HEALTH CARE CONS.

Street Address

3359 W. MAIN STREET

City / State / Zip Code

SKOKIE, IL. 60076

Phone Number

(847) 679-8219

Fax Number

(847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	577,359	15	\$ 10,580	\$	72,887	\$ 1,336	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	577,359	15	54,834	37,633	72,887	6,922	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	577,359	15	11,326		72,887	1,430	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	577,359	15	1,650		72,887	208	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	577,359	15	23,811		72,887	3,006	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	577,359	15	14,469		72,887	1,827	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	577,359	15	588,891	487,646	72,887	74,343	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	577,359	15	11,803		72,887	1,490	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	577,359	15	1,502		72,887	190	9
10	26	INSURANCE	PATIENT DAYS	577,359	15	47,685		72,887	6,020	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	577,359	15	94,969		72,887	11,989	11
12	30	DEPRECIATION	PATIENT DAYS	577,359	15	44,866		72,887	5,664	12
13	32	INTEREST	PATIENT DAYS	577,359	15	25,667		72,887	3,240	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	577,359	15	24,936		72,887	3,148	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	577,359	15	102,054		72,887	12,884	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,059,043	\$ 525,279		\$ 133,697	25

Facility Name & ID Number **WOODBRI**GE NURSING PAVILION# **0034157**

Report Period Beginning:

01/01/01Ending: **12/31/01**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

DYNAMIC HEALTH CARE CONS.

Street Address

3359 W. MAIN STREET

City / State / Zip Code

SKOKIE, IL. 60076

Phone Number

(847) 679-8219

Fax Number

(847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	62,194	62,194	5	8,272	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	45,894	45,894			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	13	398,821	398,821	5	51,248	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	12	521,536	521,536	6	69,322	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,700	191,700			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	161,003	161,003	20	64,401	6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	8	71,993	71,993	9	14,751	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	8	81,938	81,938			8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	47,846	47,846			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	96,858	96,858			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	13	139,807	139,807	7	17,968	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	9,000	9,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	13	219,069	219,069	6	29,118	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	13	63,022	63,022	5	8,098	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,110,681	\$ 2,110,683		\$ 263,178	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION# 0034157

Report Period Beginning:

01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

DYNAMIC HEALTH CARE CONS.

Street Address

3359 W. MAIN STREET

City / State / Zip Code

SKOKIE, IL. 60076

Phone Number

(847) 679-8219

Fax Number

(847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		4,545		5	605	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		3,924				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		25,461		5	3,272	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		35,957		6	4,779	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45		22,028				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		20,193		20	8,077	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		16,504		9	3,381	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		17,632				8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38		11,976				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		6,849				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		19,408		7	2,494	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40		1,068				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		29,449		6	3,914	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		8,457		5	1,087	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 223,451	\$		\$ 27,609	25

Facility Name & ID Number **WOODBIDGE NURSING PAVILION**# **0034157**

Report Period Beginning:

01/01/01Ending: **12/31/01**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

DYNAMIC REHAB CONSULTANTS, L.L.C.

Street Address

3359 W. MAIN STREET

City / State / Zip Code

SKOKIE, IL. 60076

Phone Number

(847) 679-8219

Fax Number

(847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						7,650	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						89,728	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 97,378	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHARMCOR, L.L.C.
Street Address 3116 S. OAK PARK
City / State / Zip Code BERWYN, IL 60402
Phone Number (708)795-7701
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						8,584	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	21	CLERICAL & GENERAL	DIRECT ALLOCATION						428	3
4	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							4
5	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						50,802	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 59,814	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
Street Address 3359 W. MAIN STREET
City / State / Zip Code SKOKIE, IL. 60076
Phone Number (847) 679-8219
Fax Number (847) 679-7377

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						12,474	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						10,700	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 23,174	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number WOODBIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$							1
2																			2
3																			3
4																			4
5																			5
	Working Capital																		
6	LaSalle National Bank		x	Line of Credit					977,000								55,434		6
7																			7
8																			8
9	TOTAL Facility Related						\$		\$	977,000				\$		55,434		9	
	B. Non-Facility Related*																		
10	See Supplemental Schedule																3,240		10
11	Interest Income																(54,223)		11
12	Interest Expense																13,255		12
13																			13
14	TOTAL Non-Facility Related						\$		\$					\$		(37,728)		14	
15	TOTALS (line 9+line14)						\$		\$	977,000				\$		17,706		15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC - DYNAMIC	X					\$	\$			\$ 3,240	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	\$			\$ 3,240	21

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WOODBRIDGE NURSING PAVILION

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0034157

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>13-35-217-015-0000</u>	<u>Long Term Care</u>	<u>\$ 71,120.41</u>	<u>\$ 71,120.41</u>
2.	<u>13-35-217-016-0000</u>	<u>Long Term Care</u>	<u>\$ 93,918.92</u>	<u>\$ 93,918.92</u>
3.	<u>13-35-217-017-0000</u>	<u>Long Term Care</u>	<u>\$ 71,120.41</u>	<u>\$ 71,120.41</u>
4.	<u>10-23-404-059-0000</u>	<u>Related Part Allocation</u>	<u>\$ 24,139.10</u>	<u>\$ 3,047.37</u>
5.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
6.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
7.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
8.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
9.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
10.	<u></u>	<u></u>	<u>\$</u>	<u>\$</u>
		TOTALS	\$ 260,298.84	\$ 239,207.11

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,560

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1989		3,000		20	150	150	1,862	9
10	Various		1990		20,717		20	1,036	1,036	12,298	10
11	Various		1991		11,182		20	559	559	5,915	11
12	Various		1992		14,078		20	704	(704)	6,720	12
13	Various		1993		122,812		20	6,140	6,140	53,265	13
14	Various		1995		20,549		20	1,028	1,028	6,461	14
15	Various		1996		8,331		20	417	417	2,381	15
16	Various		1997		35,913		20	1,795	1,795	8,375	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 292,583	\$ 46,694		\$ 13,429	\$ (33,265)	\$ 110,610	1
2	BRICK WORK	1998	9,222		20	461	461	1,844	2
3	TILES	1998	1,234		20	62	62	248	3
4	TILES	1998	2,278		20	114	114	447	4
5	TILES	1998	1,495		20	75	75	288	5
6	GREASE TRAP	1998	1,984		20	99	99	380	6
7	ROOF	1998	3,329		20	166	166	623	7
8	FRAME & DRYWALL	1998	750		20	38	38	139	8
9	WALL CLAY PROCESS	1998	595		20	30	30	110	9
10	FIRE ALARM	1998	2,035		20	102	102	366	10
11	HANDRAIL W/BUMPER	1998	11,827		20	591	591	2,069	11
12	BRICK WORK	1998	632		20	32	32	123	12
13	BRICK WORK	1998	589		20	29	29	111	13
14	FIRE DAMPERS	1998	495		20	25	25	83	14
15	SHEERS	1998	1,915		20	96	96	320	15
16	REMODELING	1998	11,872		20	594	594	1,931	16
17	FLOORING	1999	2,599		20	130	130	390	17
18	FIXTURES	1999	1,058		20	53	53	159	18
19	DRAPES/CORNICES	1999	699		20	35	35	105	19
20	CARPETING	1999	440		20	22	22	66	20
21	MICROSCAN UNIT	1999	1,323		20	66	66	198	21
22	BOILER TUBING	1999	2,846		20	142	142	426	22
23	HANDRAILS/GUARDS	1999	570		20	29	29	85	23
24	DOOR SYSTEM	1999	800		20	40	40	113	24
25	DOORS/CLOSETS	1999	1,321		20	66	66	187	25
26	TILES/LIGHTS	1999	1,492		20	75	75	213	26
27	FIRE ALARM SYSTEM	1999	2,440		20	122	122	346	27
28	DOOR MAGNETS	1999	915		20	46	46	127	28
29	DOOR MAGNETS	1999	2,034		20	102	102	281	29
30	DOOR MAGNETS	1999	645		20	32	32	88	30
31	CIRCUITS/OUTLETS	1999	1,350		20	68	68	187	31
32	DOOR/TILING	1999	735		20	37	37	99	32
33	CORNER GUARDS	1999	750		20	38	38	101	33
34	TOTAL (lines 1 thru 33)		\$ 364,852	\$ 46,694		\$ 17,046	\$ (29,648)	\$ 122,863	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	56,001	1,436		1,600	164	13,333	68
69	Financial Statement Depreciation		45,258			(45,258)		69
70	TOTAL (lines 4 thru 69)	\$ 292,583	\$ 46,694		\$ 13,429	\$ (34,673)	\$ 110,610	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION

0034157

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 433,557	\$ 46,694		\$ 20,484	\$ (26,210)	\$ 130,568	1
2	HANDRAILS & BUMPERS	2000	461		20	23	23	46	2
3	CUBICLE CURTAINS	2000	516		20	26	26	52	3
4	CUBICLE TRACK	2000	125		20	6	6	12	4
5	CUBICLE TRACK	2000	175		20	9	9	18	5
6	REPAIR WALLS	2000	1,611		20	81	81	162	6
7	NEW COIL	2000	1,320		20	66	66	127	7
8	INSTALL COIL	2000	710		20	36	36	69	8
9	ELEVATOR CARPET	2000	1,230		20	62	62	119	9
10	INSTALL TEST HEADER	2000	2,146		20	107	107	196	10
11	CARPET & COVE BASE	2000	2,624		20	131	131	251	11
12	WINDOW TREATMENTS	2000	1,377		20	69	69	132	12
13	VERTICAL BLINDS	2000	543		20	27	27	54	13
14	FIRE ALARM REPAIR	2000	815		20	41	41	65	14
15	INSTALL DYNALOCK	2000	1,453		20	73	73	85	15
16	ELECTRICAL FEED	2000	700		20	35	35	41	16
17	WALLPAPER	2000	1,472		20	74	74	148	17
18	PAINT/BORDERS	2000	2,885		20	144	144	288	18
19	PAINT/WALLPAPER	2000	780		20	39	39	72	19
20	WALLPAPER	2000	483		20	24	24	44	20
21	ARTWORK	2000	1,813		20	91	91	167	21
22	HVAC REPAIR	2000	893		20	45	45	60	22
23	PHONE SYSTEM	2000	10,894		20	545	545	681	23
24	WATER COOLER	2001	531		20	25	25	25	24
25	ROOF REPAIR	2001	1,190		20	50	50	50	25
26	WATER PROOFING	2001	750		20	32	32	32	26
27	ELECTRIC IMPROV	2001	1,270		20	37	37	37	27
28	SPLIT HEATING SYSTEM	2001	6,360		20	186	186	186	28
29	FURNACE	2001	32,000		20	933	933	933	29
30	CHILLER REPAIR	2001	1,180		20	34	34	34	30
31	TILE FLOOR	2001	1,300		20	38	38	38	31
32	FIRE ALARM WIRING	2001	775		20	20	20	20	32
33	SIGN	2001	716		20	18	18	18	33
34	TOTAL (lines 1 thru 33)		\$ 514,655	\$ 46,694		\$ 23,611	\$ (23,083)	\$ 134,830	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 514,655	\$ 46,694		\$ 23,611	\$ (23,083)	\$ 134,830	1
2	AIR COND COILS	2001	2,210		20	56	56	56	2
3	BOILER TUBING	2001	2,851		20	60	60	60	3
4	TUCK POINTING	2001	750		20	16	16	16	4
5	CONCRETE PAVING/STAL	2001	4,754		20	79	79	79	5
6	FIRE ALARM WIRING	2001	775		20	20	20	20	6
7	BOILER TUBING	2001	4,916		20	21	21	21	7
8	Electrical Work	2001	605		20	15	15	15	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 531,516	\$ 46,694		\$ 23,878	\$ (22,816)	\$ 135,097	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4			1993		\$ 56,001	\$ 1,436	35	\$ 1,600	\$ 164	\$ 13,333
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
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25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 56,001	\$ 1,436		\$ 1,600	\$ 164	\$ 13,333	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 292,847	\$ 3,755	\$ 28,549	\$ 24,794	10	\$ 154,292	71
72	Current Year Purchases	20,082	86	1,608	1,522	10	1,608	72
73	Fully Depreciated Assets	95,401				10	95,401	73
74								74
75	TOTALS	\$ 408,330	\$ 3,841	\$ 30,157	\$ 26,316		\$ 251,301	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	DODGE TRUCK	1993	\$ 24,451	\$	\$	\$	5	\$ 24,451	76
77		ALLOCATED - DYNAMIC	1900	7,107	386	2,227	1,841	5	2,562	77
78										78
79										79
80	TOTALS			\$ 31,558	\$ 386	\$ 2,227	\$ 1,841		\$ 27,013	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 971,404	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,921	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,262	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,341	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 413,411	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Woodbridge Building, LLC leasing from Palmer Building, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES
☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		222		\$ 1,091,170			3
4	Additions							4
5								5
6								6
7	TOTAL		222		\$ 1,091,170			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☒ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES
☒ NO

16. Rental Amount for movable equipment: \$ 20,616 Description: SEE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	LEXUS RX 300	\$ 594	\$ 1,781	17
18					18
19					19
20					20
21	TOTAL		\$ 594	\$ 1,781	21

10. Effective dates of current rental agreement:

Beginning 7/1/1995

Ending 6/30/2015

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ 1092930

13. /2003 \$ 1092930

14. /2004 \$ 1092930

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				Alloc.
7	Contractual Payments				Dynamic
8	Nurse Aide Competency Tests		208		208
9	TOTALS	\$	\$ 208	\$	\$ 208
10	SUM OF line 9, col. 1 and 2 (e)	\$	208		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 25,468	\$		\$ 25,468	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			413			413	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			63,287			63,287	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				56,857		56,857	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						21,258		21,258	13
14	TOTAL			\$		\$ 89,168	\$ 78,115		\$ 167,283	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (118,890)	\$ (118,800)	1
2	Cash-Patient Deposits	129,350	129,350	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,698,202	1,698,202	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,161	64,161	6
7	Other Prepaid Expenses	3,522	3,522	7
8	Accounts Receivable (owners or related parties)	887,963	897,963	8
9	Other(specify): See supplemental schedule	1,679	1,679	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,665,987	\$ 2,676,077	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	420,126	420,126	15
16	Equipment, at Historical Cost	441,682	441,682	16
17	Accumulated Depreciation (book methods)	(436,971)	(436,971)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(7,949)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	570	713,147	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 425,407	\$ 1,137,984	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,091,394	\$ 3,814,061	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 351,220	\$ 351,220	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	129,350	129,350	28
29	Short-Term Notes Payable	977,000	977,000	29
30	Accrued Salaries Payable	328,411	328,411	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,895	4,895	31
32	Accrued Real Estate Taxes(Sch.IX-B)	241,000	241,000	32
33	Accrued Interest Payable	13,255	13,255	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,485	14,485	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	55,000	55,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,114,616	\$ 2,114,616	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,114,616	\$ 2,114,616	46
47	TOTAL EQUITY(page 18, line 24)	\$ 976,778	\$ 1,699,445	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,091,394	\$ 3,814,061	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 958,014	1
2	Restatements (describe):		2
3	2000 LATE JOURNAL ENTRY - STATE INCOME TAX	(12,209)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 945,805	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	785,773	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(754,800)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 30,973	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 976,778	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **WOODBIDGE NURSING PAVILION**# **0034157**Report Period Beginning: **01/01/01**

Ending:

12/31/01**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,651,517	1
2	Discounts and Allowances for all Levels	(504,455)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,147,062	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,380	6
7	Oxygen	10,227	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 391,607	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,285	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,849	19
20	Radiology and X-Ray		20
21	Other Medical Services	152,665	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 241,799	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,233	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54,233	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	375	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 375	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,835,076	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,245,385	31
32	Health Care	2,505,308	32
33	General Administration	1,573,792	33
	B. Capital Expense		
34	Ownership	1,435,990	34
	C. Ancillary Expense		
35	Special Cost Centers	167,283	35
36	Provider Participation Fee	121,545	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,049,303	40
41	Income before Income Taxes (line 30 minus line 40)**	785,773	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 785,773	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **WOODBIDGE NURSING PAVILION**# **0034157**

Report Period Beginning:

01/01/01

Ending:

12/31/01**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,240	\$ 81,749	\$ 36.50	1
2	Assistant Director of Nursing	1,496	1,632	49,521	30.34	2
3	Registered Nurses	35,452	38,377	801,873	20.89	3
4	Licensed Practical Nurses	18,120	20,184	375,792	18.62	4
5	Nurse Aides & Orderlies	88,816	93,740	813,633	8.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,882	2,034	20,027	9.85	9
10	Activity Assistants	16,280	16,819	101,991	6.06	10
11	Social Service Workers	3,213	3,447	25,138	7.29	11
12	Dietician					12
13	Food Service Supervisor	3,824	4,120	59,683	14.49	13
14	Head Cook	5,774	6,182			14
15	Cook Helpers/Assistants	16,831	17,697	171,094	9.67	15
16	Dishwashers					16
17	Maintenance Workers	5,356	5,668	57,038	10.06	17
18	Housekeepers	12,359	12,706	94,330	7.42	18
19	Laundry	2,405	2,457	21,009	8.55	19
20	Administrator	1,912	2,120	96,025	45.29	20
21	Assistant Administrator	1,000	1,000	11,516	11.52	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,369	8,978	99,560	11.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,144	2,299	37,681	16.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,185	241,701	\$ 2,917,660 *	\$ 12.07	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	382	\$ 7,200	01-03	35
36	Medical Director	96	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	66	21,180	10-03	38
39	Pharmacist Consultant	99	5,008	10-03	39
40	Physical Therapy Consultant	96	3,850	10a-03	40
41	Occupational Therapy Consultant	95	3,800	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	4,400	11-03	44
45	Social Service Consultant		4,198	12-03	45
46	Other(specify)				46
47	Utilization Review	96	1,200	10-03	47
48					48
49	TOTAL (lines 35 - 48)	1,026	\$ 54,436		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,246	15,154	10-03	51
52	Nurse Aides	2,354	33,425	10-03	52
53	TOTAL (lines 50 - 52)	3,600	\$ 48,579		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jay Gonzalez	Administrator		\$ 96,025
Iris Ehrlicher	Asst. Administator		11,516
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 107,541
B. Administrative - Other			
Description			Amount
Management Fees - Dynamic Healthcare			\$ 180,565
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 180,565
C. Professional Services			
Vendor/Payee	Type		Amount
Sachoff and Weaver	Legal		\$ 9,329
Econocare, Inc	Purchasing Services		3,996
Frost, Ruttenberg & Rothblatt	Accounting		24,282
Health Data Systems	Data Processing		4,501
Hansen Associates			350
Dynamic Healthcare Consulting	Bookeeping Services		310,790
Personnel Planners, Inc	Unemployment Consulting		1,221
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 354,469
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 58,334
Unemployment Compensation Insurance			26,393
FICA Taxes			220,562
Employee Health Insurance			
Employee Meals			26,335
Illinois Municipal Retirement Fund (IMRF)*			
Chicago Head Tax			6,210
Hospitalization Insurance			182,847
Employee Benefits			19,579
TOTAL (agree to Schedule V, line 22, col.8)			\$ 540,260
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 200
Advertising: Employee Recruitment			4,324
Health Care Worker Background Check (Indicate # of checks performed 18)			252
Licenses and Fees			2,177
Dues and Subscriptions			5,797
Promotional Advertising			37,628
Alloc-Dynamic			1,827
Yellow Page Advertising			1,895
Less: Public Relations Expense			
Non-allowable advertising			(37,628)
Yellow page advertising			(1,895)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 14,577
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,114
Alloc-Dynamic			1,490
Entertainment Expense			
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 2,604

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number		WOODBRIDGE NURSING PAVILION		STATE OF ILLINOIS				Page 23
		#	0034157	Report Period Beginning:	01/01/01	Ending:	12/31/01	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

ICLTC -

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 5,155 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

x YES NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 121,545

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 26,335
No

(16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
No
100%
Yes
No
N/A

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees

Yes

11/7/2005 4:36 PM